ARCHITECTURAL DESIGN INVOICE

Healthcare Infrastructure Specialist

Invoice #: [00000]
Date: [Date]
Project ID: [HC-000]

DESIGN CONSULTANT

[Firm Name]
[Street Address]
[City, State, Zip]
[Email/Phone]

CLIENT / HEALTHCARE FACILITY

[Facility Name]
[Department/Attention]
[Street Address]
[City, State, Zip]

PROJECT: [FACILITY NAME / EXTENSION DESCRIPTION]

Phase / Service Description	Rate/Unit	Qty/Hrs	Amount
Schematic Design Clinical flow analysis and initial spatial programming	$0.00	0	$0.00
Medical Equipment Planning Integration of specialized diagnostic imaging suites	$0.00	0	$0.00
Regulatory Compliance Review State health department and ADA accessibility auditing	$0.00	0	$0.00
Construction Documentation Detailed MEP and architectural blueprints	$0.00	0	$0.00

Subtotal:	$0.00
Reimbursable Expenses:	$0.00
Total Due:	**$0.00**

PAYMENT TERMS & NOTES

Please make checks payable to **[Firm Name]**. Net 30 days. Late payments are subject to a [0%] monthly interest charge. This invoice covers professional services rendered in accordance with the Architectural Services Agreement.